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MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

STANDARD CERTIFICATE OF DEATH

Arizona State Board of Health

BUREAU OF VITAL STATISTICS

STATE FILE NO. 132

1. PLACE OF DEATH — STATE ARIZONA — REGISTERED NO. 450

COUNTY Maricopa — OR VILLAGE — OR WARD

TOWNSHIP — CITY Phoenix — NO. Good Samaritan ST.

(IF DEATH OCCURRED IN HOSPITAL OR INSTITUTION, GIVE ITS NAME INSTEAD OF STREET AND NUMBER)

LENGTH OF RESIDENCE IN CITY OR TOWN WHERE DEATH OCCURRED Not known YRS. MOS. DS. HOW LONG IN U. S. IF OF FOREIGN BIRTH? YRS. MOS. DS.

HOW LONG IN STATE WHERE DEATH OCCURRED? 51 YRS. MOS. DS.

2. FULL NAME Frank Bird

(A) RESIDENCE: NO. ST. WARD.

(USUAL PLACE OF ABODE) (IF NON-RESIDENT GIVE CITY OR TOWN AND STATE)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (WRITE THE WORD)
Male	white	not known

5A. IF MARRIED, WIDOWED, OR DIVORCED — HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS	MONTHS	DAYS	IF LESS THAN 1 DAY, HRS. OR MIN.
about 71			

OCCUPATION

8. TRADE, PROFESSION, OR PARTICULAR KIND OF WORK DONE, AS SPINNER, SAWYER, BOOKKEEPER, ETC. Not known

9. INDUSTRY OR BUSINESS IN WHICH WORK WAS DONE, AS SILK MILL, SAW MILL, BANK, ETC.

10. DATE DECEASED LAST WORKED AT THIS OCCUPATION (MONTH AND YEAR)

11. TOTAL TIME (YEARS) SPENT IN THIS OCCUPATION

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTY) Not known

FATHER

13. NAME " "

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTY) " "

MOTHER

15. MAIDEN NAME " "

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTY) " "

17. INFORMANT (ADDRESS) Hospital record

18. BURIAL, CREMATION, OR REMOVAL — PLACE Glenwood Mem — DATE 4/10, 1935

19. EMBALMER — LICENSE NO. — SIGNATURE — FUNERAL DIRECTOR — ADDRESS

20. FILED 4-11-35 19 — Dr. O. W. Schemm REGISTRAR

10M—11-22-34—REP-GAZ PRINTERY—FORM 2

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/8/35

22. I HEREBY CERTIFY, THAT I ATTENDED DECEASED FROM 4-1, 1935 TO 4-8, 1935, I LAST SAW H— ALIVE ON 4-8, 1935 DEATH IS SAID TO HAVE OCCURRED ON THE DATE STATED ABOVE, AT M.

THE PRINCIPAL CAUSE OF DEATH AND RELATED CAUSES OF IMPORTANCE WERE AS FOLLOWS: — DATE OF ONSET

Myocarditis Chr
Hy postatic Pneumonia Acute

OTHER CONTRIBUTORY CAUSES OF IMPORTANCE:

NAME OF OPERATION — DATE OF

WHAT TEST CONFIRMED DIAGNOSIS? — WAS THERE AN AUTOPSY?

23. IF DEATH WAS DUE TO EXTERNAL CAUSES (VIOLENCE) FILL IN ALSO THE FOLLOWING: ACCIDENT, SUICIDE, OR HOMOCIDE? — DATE OF INJURY — 19—

WHERE DID INJURY OCCUR? (SPECIFY CITY OR TOWN, COUNTY AND STATE)

SPECIFY WHETHER INJURY OCCURRED IN INDUSTRY, IN HOME, OR IN PUBLIC PLACE

MANNER OF INJURY

NATURE OF INJURY

24. WAS DISEASE OR INJURY IN ANY WAY RELATED TO OCCUPATION OF DECEASED?

IF SO, SPECIFY

(SIGNED) M. D.

(ADDRESS)

BACK OF CERTIFICATE TO BE USED FOR ANY ADDITIONAL INFORMATION